



MANAGEMENT – INITIATED REFERRAL

A management – initiated referral to the Employee Assistance Program (EAP) is appropriate when management recognizes serious work performance problems related to alcohol/drug use, severe emotional issues or safety issues. A referral to the EAP should always be made for a positive drug/alcohol test or refusal to take the test.

Management should meet with the employee to discuss the referral. An authorization form to release information regarding services (see attached) should be signed and dated by the employee and the Referral Contact. The form should specifically indicate which information could be released to the Referral Contact. Please note that without the signed authorization, ComPsych will not be able to release any information regarding the employee's participation in the program. The form should be faxed back to the Management Referral Team at 312-705-6375.

Once the employee agrees to seek EAP services, the Referral Contact should call ComPsych Intake Department regarding the referral. The Guidance Consultant will gather information regarding the reason for the referral, employer's expectation regarding the referral, and name and telephone/fax number of the Referral Contact.

The employee should be instructed to call ComPsych Intake Department within twenty-four (24) hours of the referral to arrange for a face-to-face assessment. The local EAP provider will determine the most appropriate course of treatment to help the employee address and resolve work related issues. The provider will not make return to work recommendations.

The Management Referral Specialist (MRS) will provide the Referral Contact with the information regarding recommendations to resolve the issue and the employee's compliance with the recommendations.

If you need additional information or need assistance with a referral, please contact ComPsych's Intake Department.

Revised 09/2003



AUTHORIZATION FORM: Management Referral

I, the undersigned, hereby authorize ComPsych's Management Referral Specialist to release to:

(Name of the Referral Contact or Entity)

(Name of the Company or Entity)

the following information contained in the clinical record maintained by ComPsych:

- ✓ Initial appointment kept
- ✓ Treatment recommendations made
- ✓ Compliance with the recommended treatment
- ✓ Completion of the recommended treatment
- ✓ Results of Drug/Alcohol tests, if applicable

My authorization for the release of the above information is effective on the date I sign this form and will remain effective for a period of one (1) year from such date.

The purpose of the disclosure by ComPsych to the recipient is:

To report my compliance/non-compliance with the management referral process.

I understand that ComPsych will not condition treatment or payment or the eligibility of my receiving services on the basis of my providing authorization for the requested use or disclosure, and that I may refuse to sign this authorization. To the extent that I do sign this authorization, I do so voluntarily. I understand that I have the right to inspect and copy the information that I have authorized to be used or disclosed as provided for under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations found at 45 C.F.R. § 164.524.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked by me before then. I understand that I may revoke this authorization at any time by sending written notice to ComPsych. I understand that if I revoke this authorization such revocation will not be effective to the extent ComPsych has already relied on it to disclose the information.

Signed: _____ Date: _____

Witness: _____ Date: _____

Client Name:	Date of Birth:
Client Address:	